

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005124</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST VINCENT HOSPICE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8450 N PAYNE RD STE 100 INDIANAPOLIS, IN 46268</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was the 2015 ISDH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements at 410 IAC 7-24.</p> <p>Facility Number: 005124</p> <p>Survey Dates: 4/29/2015</p> <p>Surveyors:</p> <p>QR: JE 5/4/15</p> <p>St. Vincent Hospice was in compliance with 410 IAC 7-24 during their routine kitchen sanitation inspection.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE